



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

July 2, 2019

Ms. Ann Schumacher, Manager
Hawk Lane
58 Hawk Lane
Hinesburg, VT 05461-8803

Dear Ms. Schumacher:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 12, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink, appearing to read "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2019
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAWK LANE

58 HAWK LANE
HINESBURG, VT 05461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------------	--	---------------------	--	--------------------------

T 001 Initial Comments

T 001

An unannounced on-site re-licensure survey was conducted by the Division of Licensing and Protection on 6/12/19 to determine compliance with the Licensing and Operating Regulations for the Therapeutic Community Residences (TCR). The following regulatory violation was identified:

T 037 V.5.8.c Resident Care and Services
SS=D

T 037

5.8 Medication Management

5.8.c Staff shall not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's or other licensed health care provider's written, signed order and supporting diagnosis or problem statement in the resident's record.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the Therapeutic Community Residence (TCR) failed to assure all medications administered had a physician's or other licensed health care provider's, written, signed order for 1 of 2 applicable records reviewed: (Resident #1) Findings include:

Per review of the Medication Administration Record, Resident #1 had a change in physician orders for Risperdal 0.5 mg (antipsychotic). Initially, Resident #1 had been receiving Risperdal 0.5 mg x 1 in the morning and Risperdal 1 mg at bed time. However, due to feeling the morning dose interfered with the resident's ability to take part in activities, the morning dose of Risperdal was discontinued in

1. SIGNED ORDER IS NOW
PRESENT IN THE RECORD.
SEE ATTACHED.

2. ONGOING TRAINING WHEN
ONBOARDING NEW NURSES
REGARDING COMPLIANCE WITH
TCR REGULATIONS.

TRAINING WILL INCLUDE
IMMEDIATE SIGNATURE OF
THE PHYSICIAN AT THE APPT.
WITHOUT DELAY

RESIDENTIAL MANAGERS TO
INSURE COMPLIANCE WITH
PHYSICIAN SIGNATURES ON
ALL MEDICATION ORDERS.

T037 POL accepted 7/1/19 Fmldtshrd/PMU

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

[Signature] Team Lead 6/26/19

1BJU11

If continuation sheet 1 of 2

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2019
NAME OF PROVIDER OR SUPPLIER HAWK LANE		STREET ADDRESS, CITY, STATE, ZIP CODE 58 HAWK LANE HINESBURG, VT 05461	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
T 037	Continued From page 1 February 2019 and Resident #1 would now receive Risperdal 0.5 mg x 3 (total of 1.5 mg) at bed time. Upon review of physician orders, there was no signed order for the change in medication dose and time. This omission was confirmed on the morning of 6/12/19 by the TCR Registered Nurse (RN).	T 037	